Before the
WORKERS' COMPENSATION BOARD
State of Oregon

Request Type: ☐ Initial ☐ Supplemental ☐ Amended ☐ Consolidate w/WCB # ____________

Requested by: ☐ Atty/Claimant ☐ Claimant ☐ Insurer/Processor ☐ Employer ☐ DCBS

In the Matter of the Compensation of

Name ____________________
Address ____________________
____
Phone # ____________________

Claimant's Attorney ____________________
Oregon State Bar # ____________________
Attorney Firm ____________________
Address ____________________
____
Phone # ____________________

Request for Hearing and Specification of Issues

Date of Injury ____________________
Claim # ____________________
(only one claim number per form)
WCD File # ____________________

Employer ____________________
Address ____________________
____
Insurer ____________________
Address ____________________
____

Parties must notify WCB of any address changes

A hearing is requested for the reason(s) checked below:

☐ **A** DENIAL *(date)* ____________________
- ☐ **B** Compensability - complete claim denial
- ☐ **X** Partial denial after a claim acceptance
- ☐ **Z** Challenge to notice of acceptance
- ☐ **V** Worker noncooperation
- ☐ **K** Aggravation
- ☐ **L** Responsibility
- ☐ **C** Medical services (ORS 656.245)

☐ **M** NONCOMPLYING EMPLOYER ORDER

☐ **O** TEMPORARY DISABILITY
- ☐ **R** Rate
- ☐ **D** Period sought ____________________

☐ **F** SUPPLEMENTAL TEMPORARY DISABILITY
(2nd Employer) Period sought ____________________

☐ **N** ORDER ON RECONSIDERATION **attach copy**
- ☐ **Y** Classification *(disabling/nondisabling)*
- ☐ **I** Premature closure
- ☐ **E** Temporary disability
  Period sought ____________________
- ☐ **H** Permanent partial disability
- ☐ **G** Permanent total disability

☐ **Q** OTHER *(Explain and cite ORS)* ____________________
____

☐ **P** DIRECTOR'S ORDER **attach copy**
☐ **S** PENALTY *(Cite ORS)* ____________________
☐ **T** ATTORNEY FEE *(Cite ORS)* ____________________
☐ **W** COSTS

- **INTERPRETER WILL BE NEEDED - Language:** ____________________ ☐ Yes ☐ No
- Amount in controversy is LESS than $1000 (ORS 656.291). ☐ Yes ☐ No
- Compensation stayed *(Carrier appeal of Order on Reconsideration).* ☐ Yes ☐ No
- All day is required for hearing. ☐ Yes ☐ No
- Half day is required for hearing. ☐ Yes ☐ No

NOTICE TO OPPOSING PARTY:

The requesting party demands copies of all medical reports and all other documents pertaining to this claim regardless of whether the responding party intends to rely on them at hearing.

____________________ ____________________
Signature of Requester Date

(Rev 5/2016)